

		FOR OHF USE					

LL 1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0014290</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>The Clayberg</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/01</u> to <u>11/30/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>625 E. Monroe, P.O. Box 200</u> <u>Cuba</u> <u>61427</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Fulton</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Charles Ackers</u> (Title) <u>Administrator</u>																									
Telephone Number: <u>(309) 785-5012</u> Fax # <u>(309) 785-5376</u>		Paid Preparer (Signed) <u>compilation report is attached</u> (Date) _____ (Print Name and Title) <u>John P. Lehman</u> <u>Partner</u> (Firm Name & Address) <u>Clifton Gunderson, LLP</u> <u>301 SW Adams, Ste 900, PO Box 1835, Peoria, IL 61656-1835</u> (Telephone) <u>(309) 671-4500</u> Fax # <u>(309) 671-4508</u>																									
IDPA ID Number: <u>370914241001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>7/6/69</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County																									
	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact: Name: <u>Charles Ackers</u> Telephone Number: <u>(309) 785-5012</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

#	0014290	Report Period Beginning:	12/1/01	Ending:	11/30/02
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D. How many bed-hold days during this year were paid by Public Aid?

49

99 (Do not include bed-hold days in Section B.)

none

yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 7/6/69

YES ☐ Date _____ NO ☒

YES ☐ NO ☒ If YES, enter number

of beds certified _____ and days of care provided _____

IV. ACCOUNTING BASIS

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 11/30/02 **Fiscal Year:** 11/30/02

* All facilities other than governmental must report on the accrual basis.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.08%

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	10,407	6,956		17,363	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,407	6,956		17,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)		97.08%
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STATE OF ILLINOIS

Page 3

Facility Name & ID Number

The Clayberg

0014290

Report Period Beginning:

12/1/01

Ending:

11/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	160,527	8,228	2,928	171,683		171,683		171,683		1
2	Food Purchase		89,613		89,613		89,613	(3,530)	86,083		2
3	Housekeeping	135,557	4,545		140,102		140,102		140,102		3
4	Laundry		9,820		9,820		9,820		9,820		4
5	Heat and Other Utilities			43,215	43,215		43,215	(1,830)	41,385		5
6	Maintenance	46,266	19,582	17,225	83,073		83,073		83,073		6
7	Other (specify):*										7
8	TOTAL General Services	342,350	131,788	63,368	537,506		537,506	(5,360)	532,146		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	657,084	29,048	942	687,074		687,074		687,074		10
10a	Therapy	37,736		10,097	47,833		47,833		47,833		10a
11	Activities	56,322	12,044	1,412	69,778		69,778		69,778		11
12	Social Services	19,961		1,413	21,374		21,374		21,374		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	771,103	41,092	13,864	826,059		826,059		826,059		16
	C. General Administration										
17	Administrative	52,570		638	53,208		53,208		53,208		17
18	Directors Fees										18
19	Professional Services			2,800	2,800		2,800		2,800		19
20	Dues, Fees, Subscriptions & Promotions			8,118	8,118		8,118	(4,191)	3,927		20
21	Clerical & General Office Expenses	28,268	9,922	5,714	43,904		43,904	4,260	48,164		21
22	Employee Benefits & Payroll Taxes			235,495	235,495		235,495	131,555	367,050		22
23	Inservice Training & Education			1,793	1,793		1,793		1,793		23
24	Travel and Seminar			1,208	1,208		1,208		1,208		24
25	Other Admin. Staff Transportation			840	840		840		840		25
26	Insurance-Prop.Liab.Malpractice			36,836	36,836		36,836		36,836		26
27	Other (specify):*										27
28	TOTAL General Administration	80,838	9,922	293,442	384,202		384,202	131,624	515,826		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,194,291	182,802	370,674	1,747,767		1,747,767	126,264	1,874,031		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Clayberg

#0014290

Report Period Beginning:

12/1/01

Ending:

11/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			55,638	55,638		55,638		55,638			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53	53		53	(53)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			55,691	55,691		55,691	(53)	55,638			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		794		794		794		794			39
40	Barber and Beauty Shops			1,055	1,055		1,055		1,055			40
41	Coffee and Gift Shops		3,949		3,949		3,949	(3,949)				41
42	Provider Participation Fee			26,828	26,828		26,828		26,828			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		4,743	27,883	32,626		32,626	(3,949)	28,677			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,194,291	187,545	454,248	1,836,084		1,836,084	122,262	1,958,346			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/01

Ending: 11/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(3,530)	2		4
5 Telephone, TV & Radio in Resident Rooms	(1,830)	5		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(53)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment	(752)	22		19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(3,087)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(5,053)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,305)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
Amortization of Organization &			
33 Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	136,567	see VII	34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 136,567		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 122,262		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

The ClaybergID# 0014290Report Period Beginning: 12/1/01Ending: 11/30/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	lobbying portion of dues	\$ (1,104)	20	1
2	vending machine costs	(3,949)	41	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,053)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/01

Ending:

11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,530)	0	0	0	0	0	0	0	0	0	0	(3,530)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,830)	0	0	0	0	0	0	0	0	0	0	(1,830)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,360)	0	0	0	0	0	0	0	0	0	0	(5,360)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,191)	0	0	0	0	0	0	0	0	0	0	(4,191)	20
21	Clerical & General Office Expenses	0	4,260	0	0	0	0	0	0	0	0	0	4,260	21
22	Employee Benefits & Payroll Taxes	(752)	132,307	0	0	0	0	0	0	0	0	0	131,555	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,943)	136,567	0	0	0	0	0	0	0	0	0	131,624	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,303)	136,567	0	0	0	0	0	0	0	0	0	126,264	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Clayberg# 0014290

Report Period Beginning:

12/1/01

Ending:

11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(53)	0	0	0	0	0	0	0	0	0	0	(53)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(53)	0	0	0	0	0	0	0	0	0	0	(53)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(3,949)	0	0	0	0	0	0	0	0	0	0	(3,949)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(3,949)	0	0	0	0	0	0	0	0	0	0	(3,949)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(14,305)	136,567	0	0	0	0	0	0	0	0	0	122,262	45

Facility Name & ID Number The Clayberg# 0014290

Report Period Beginning:

12/1/01

Ending:

11/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Fulton County</u>	<u>100</u>	<u>none</u>		<u>Fulton County</u>	<u>Lewistown</u>	<u>county govt</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 payroll and accounts payable	\$	<u>Fulton County</u>	<u>100.00%</u>	\$ <u>4,260</u>	\$ <u>4,260</u>	1
2	V	22 health insurance	<u>74,454</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>206,761</u>	<u>132,307</u>	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>74,454</u>			\$ <u>211,021</u>	\$ * <u>136,567</u>	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/01 Ending: 11/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	none								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/01 Ending: 11/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	xerox corporation		x	copier equipment capital lease	\$46.10	6/21/00	\$ 1,450	\$ 314	6/21/03	9.0000	\$ 53	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$46.10		\$ 1,450	\$ 314			\$ 53	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,450	\$ 314			\$ 53	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **The Clayberg**# **0014290** Report Period Beginning: **12/1/01** Ending: **11/30/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2001 report.		\$	none	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	none	2
3. Under or (over) accrual (line 2 minus line 1).		\$	none	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	none	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	none	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	none	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	none	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997 _____	8		
	1998 _____	9		
	1999 _____	10		
	2000 _____	11		
	2001 _____	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	The Clayberg	COUNTY	Fulton
---------------	--------------	--------	--------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet: 14,920

B. General Construction Type: Exterior brick Frame concrete block & steel Number of Stories one

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>building site</u>	<u>217,800</u>	<u>1969</u>	<u>\$ 5,000</u>	1
2					2
3	TOTALS	217,800		\$ 5,000	3

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/01

Ending:

11/30/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1969	1969	\$ 271,336	\$ 6,783	40	\$ 6,783		\$ 224,204	4
5				1977	6,286		20			6,286	5
6				1978	8,009		20			8,009	6
7				1979	52,592	1,737	30	1,737		42,173	7
8				1980	23,875		10			23,875	8
		Improvement Type**									
9		windows and plaster repair		1081	17,092		3 to 10			17,092	9
10		fire alarm and sprinkler system, front porch and patio		1982	8,432		5 to 20			8,432	10
11		office remodeling		1983	3,273		5 to 10			3,273	11
12		roof		1984	2,005		10			2,005	12
13		canvas,floors,sewer,box,sign,door		1985	17,304	322	15 to 25	322		14,929	13
14		roof and shutters		1986	3,066	16	15 to 25	16		2,940	14
15		shed, roof and floor tile		1987	17,275	983	15 to 25	983		15,867	15
16		heating and cooling system		1988	9,166	458	20	458		6,493	16
17		IDPA adjustment		1989	1,806	90	20	90		541	17
18		new shed		1990	8,284	552	15	552		6,765	18
19		new shed		1991	10,876	725	15	725		8,398	19
20		drain		1992	743	50	15	50		528	20
21		roof and greenhouse		1993	62,282	4,152	15	4,152		41,181	21
22		road repair		1994	13,496		5			13,496	22
23		storage building addition		1994	4,264	213	20	213		1,511	23
24		storage building addition		1996	12,141	607	20	607		4,030	24
25		laundry facility		1997	15,274	764	20	764		4,296	25
26		carpet		2000	1,734	173	10	173		491	26
27		heating and cooling system		2000	4,564	228	20	228		494	27
28		walk path		2001	4,177	279	15	279		325	28
29		aviary		2002	4,740	132	15	132		132	29
30		walk path		2002	1,357	38	15	38		38	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 585,449	\$ 18,302		\$ 18,302	\$	\$ 457,804	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 250,928	\$ 21,865	\$ 21,865	\$	5 to 20	\$ 140,957	71
72	Current Year Purchases	8,568	224	224		5 to 10	224	72
73	Fully Depreciated Assets	127,851	1,956	1,956		3 to 10	127,851	73
74								74
75	TOTALS	\$ 387,347	\$ 24,045	\$ 24,045	\$		\$ 269,032	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	pickup, delivery and plowing	2001 Ford truck with plow	2001	\$ 23,817	\$ 4,763	\$ 4,763	\$	5	\$ 7,145	76
77	patient transportation	2000 Chevy bus	2000	42,641	8,528	8,528		5	19,899	77
78										78
79										79
80	TOTALS			\$ 66,458	\$ 13,291	\$ 13,291	\$		\$ 27,044	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,044,254	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,638	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,638	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 753,880	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>no nurse aides were trained during this report period because the facility hired only aides who were already certified.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language Development Therapist		hrs								2
2	Licensed Recreational Therapist		hrs								3
3	Licensed Physical Therapist		hrs								4
4	Physician Care		visits								5
5	Dental Care		visits								6
6	Work Related Program		hrs								7
7	Habilitation		hrs								8
8			# of prescrpts								9
9	Pharmacy										
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify): prescription drugs	39-2					794		794		13
14	TOTAL			\$		\$	\$ 794		\$ 794		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 355,845	\$	1
2	Cash-Patient Deposits	513		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	214,204		3
4	Supply Inventory (priced at cost)	4,156		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 574,718	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	150,000		12
13	Land	5,000		13
14	Buildings, at Historical Cost	585,449		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	453,805		16
17	Accumulated Depreciation (book methods)	(753,880)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 440,374	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,015,092	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 15,319	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	513		28
29	Short-Term Notes Payable	314		29
30	Accrued Salaries Payable	48,929		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accrued compensated absences	113,011		36
37	county assessment payable	8,049		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 186,135	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 186,135	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 828,957	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,015,092	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 831,789	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 831,789	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(198,658)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (198,658)	17
	B. Transfers (Itemize):		
18	transfer in from county IMRF fund	42,726	18
19	transfer in from county FICA fund	91,363	19
20	transfer in from county general fund	638	20
21	transfer in from county insurance fund	60,945	21
22	transfer in from county unemployment insurance fund	154	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 195,826	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 828,957	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,565,892	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,565,892	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,930	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,530	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,460	23
	D. Non-Operating Revenue		
24	Contributions	42,393	24
25	Interest and Other Investment Income***	19,681	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62,074	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,637,426	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	537,506	31
32	Health Care	826,059	32
33	General Administration	384,202	33
	B. Capital Expense		
34	Ownership	55,691	34
	C. Ancillary Expense		
35	Special Cost Centers	5,798	35
36	Provider Participation Fee	26,828	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,836,084	40
41	Income before Income Taxes (line 30 minus line 40)**	(198,658)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (198,658)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number The Clayberg# 0014290Report Period Beginning: 12/1/01Ending: 11/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	2,199	\$ 44,319	\$ 20.15	1
2	Assistant Director of Nursing	2,017	2,218	39,642	17.87	2
3	Registered Nurses					3
4	Licensed Practical Nurses	10,874	12,123	154,562	12.75	4
5	Nurse Aides & Orderlies	43,124	47,523	382,562	8.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,660	4,245	37,736	8.89	8
9	Activity Director	1,747	1,968	22,175	11.27	9
10	Activity Assistants	4,220	4,621	34,147	7.39	10
11	Social Service Workers	2,292	2,373	19,961	8.41	11
12	Dietician					12
13	Food Service Supervisor	1,781	2,132	30,962	14.52	13
14	Head Cook	9,178	10,587	91,791	8.67	14
15	Cook Helpers/Assistants	4,770	5,412	37,774	6.98	15
16	Dishwashers					16
17	Maintenance Workers	3,562	4,109	46,266	11.26	17
18	Housekeepers	15,762	17,335	135,557	7.82	18
19	Laundry					19
20	Administrator	1,836	1,962	52,570	26.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,776	2,150	28,268	13.15	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care plan coordinators	1,780	2,118	35,999	17.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,299	123,075	\$ 1,194,291 *	\$ 9.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 2,928	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	534	10-3	39
40	Physical Therapy Consultant	84	3,600	10a-3	40
41	Occupational Therapy Consultant	81	5,955	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	542	10a-3	43
44	Activity Consultant	36	1,412	11-3	44
45	Social Service Consultant	36	1,413	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	391	\$ 16,384		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/01

Ending: 11/30/02

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **The Clayberg**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IHCA \$2781, CNHA \$480
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,041 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 26,828
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 3,530
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transportation residents to and from day training?** no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Clifton Gunderson, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. report will be issued in May
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.